Richard Gottlieb, M.D., Psy.D.

Psychiatry and Psychoanalysis

PATIENT INFORMATION

NAME:_____ M: [ ] S: [ ] D: [ ] W: [ ]

ADDRESS: _____ M: [ ] F: [ ]

CITY: _____ STATE: _____ ZIPCODE: _____

DOB: _____/_____/_____ AGE: _____ SS#:_____-_____-_____

HOME #:(_____) _____ - _____ CELL #:(_____) _____ - _____

EMPLOYER_____ WORK# (_____)_____-_____

INSURED INFORMATION

NAME: _____ RELATIONSHIP_____

ADDRESS: _____ M: [ ] F: [ ]

CITY: _____ STATE:_____ ZIPCODE: _____

DOB: _____/_____/_____ AGE: _____ SS#: _____ - _____ - _____

HOME #: (_____) _____ - _____ CELL #: (_____) _____ - _____

EMPLOYER_____ WORK# (_____)_____-_____

INSURANCE INFORMATION

INSURANCE CO:_____ PHONE # (_____)_____-_____

ID#_____ GROUP #_____

AUTHORIZATION #_____ DATE OBTAINED:_____

(IF YOUR INSURANCE COMPANY REQUIRES AUTHORIZATION AND YOU DID NOT OBTAIN ONE YOU WILL BE RESPONSIBLE FOR PAYMENT)

EMERGENCY CONTACT

NAME:_____PHONE #_____RELATIONSHIP_____

PLEASE READ, SIGN, AND DATE THE FOLLOWING PAGES AND RETURN TO THE FRONT DESK.

WELCOME TO MY PRACTICE!

I welcome you as a patient and appreciate the opportunity to provide you with my services. I want you to know, from the start, my policies and methods of practice.

***Practice hours*:** My hours vary from day to day, so please check my website for my daily hours of operation.

Appointments: Please note that 24 business hours prior to your appointment is required for cancellation. I have reserved that time specifically for you. Please call my office at (480) 477-7993 if you need to cancel or reschedule. You will be charged a Late Cancellation/No-Show fee if adequate notice is not given.

Routine daytime telephone calls: All patients are encouraged to call if there is a problem. However, please understand that your call will be returned at the earliest opportunity and that because of my busy work schedule, I may not be able to return the call until the end of my workday. If I have not returned your call by then, please call back the next day as the voicemail system may have malfunctioned.

Emergency after hours telephone calls: If you need to call after hours, the answering service will forward your call to me (or the doctor on call) and appropriate action will be taken. Please note that there may be a charge for these calls if they are lengthy or if more than one call is made. The answering service is reserved solely for emergencies and urgent matters. If you have a need to reschedule or have other non-emergency questions, please call back during my normal office hours.

Fees and payments: I make every effort to keep the cost of your medical care down. You can help by paying your copayment or bill at the time of service. You will be charged the full fee if *not* covered by insurance for No-Shows or Late Cancellations. If you are covered by insurance, you will be charged $50 for visits missed with less than one business days' notice. I charge the full fee of $450 for New Patient Intakes if not cancelled with at least one business days' notice, since I reserved one hour specifically for you and insurance companies do not pay for unattended appointments. I will not reschedule new patients who have missed their Intake appointments unless that $450 fee is paid in advance. If you need me to complete paperwork, such as disability forms, please note that a reasonable fee will be charged. I accept cash, check, or credit card payments. However, please note, that I charge a 5% processing fee for credit card payments.

Divorce/custody: The parent and/or legal guardian who brings the child in for medical services will be responsible for any payment due at the time of services. I do not bill third parties regardless of what the decree or custody documents indicate. Please provide full custodial documentation for release of medical information.

Insurance authorizations and claims: If your insurance company requires treatment to be pre-authorized, it is **your responsibility** to obtain this. If you do not obtain preauthorization and your insurance company refuses to pay my charges, you will be responsible for payment in full. I file insurance claims for your outpatient office visits. Please remember filing insurance claims is a service provided without charge, however, it does not relieve you of your responsibility to pay any balance owed. It remains your responsibility to pay claims if my services for any reason are not covered by your insurance company.

Prescriptions and renewals: All prescriptions and authorizations for renewals should be requested during my usual office hours, and not by telephone unless an emergency. You will be charged a reasonable fee if you need me to refill prescriptions in between appointments and it is not because of an error that I made.

Confidentiality: All information you provide to me is confidential, with your written consent required for release of any information. Please remember that if you are billing insurance company for your treatment you already have signed a release to allow me to copy your medical records to your insurance company so that they may determine that medically appropriate and/or necessary treatment is being rendered. Other exceptions occur for minors and for those who pose an imminent danger to themselves or others. Also, information may be shared, if necessary, with an on-call doctor.

I UNDERSTAND THESE CLINIC POLICIES AND AGREE TO FOLLOW THEM

PATIENT_____ **DATE**_____

RESPONSIBLE PARTY_____ **DATE**_____

GENERAL CONSENT TO TREAT

I, the undersigned, hereby request and consent to treatment rendered by Dr. Gottlieb. I understand that this consent is for voluntary treatment on an out-patient basis. I understand that as a voluntary out-patient, I am free to review my treatment plan, and that if I disagree with any aspect of it my clinician will try to offer an acceptable alternative treatment plan. Should he insist that no reasonable alternative exists, and I still refuse the recommended treatment, I understand that Dr. Gottlieb may elect to withdraw his services or refer me to another clinician, psychiatrist, or mental health professional. I also understand that I retain the right to refuse any recommended medication, and/or any lab test ordered. I understand that my treatment may be for an emotional, psychological, or relationship problem for which I may be prescribed therapy, medication, counseling, psychological testing, or any of the above in combination. I hereby consent to follow treatment suggestions, or to directly inform Dr. Gottlieb of my objections to doing so if any.

By signing this consent, I am agreeing to report any suicidal or homicidal feelings to Dr. Gottlieb. I hereby agree to call him, or his backup doctor should my suicidal or homicidal feelings intensify to the point that I feel unable to prevent myself from acting on them. I further understand that Dr. Gottlieb may suggest I enter a hospital at that time for my own protection or for the protection of others. In such a case I understand I will be asked to voluntarily agree to hospitalization. Should I refuse admission as recommended at that time for any reason, I understand that Dr. Gottlieb may contact the public mental health authority and/or the local police department to institute an involuntary hospitalization for your safety.

I understand that Dr. Gottlieb desires to permit the maximum amount of freedom possible in the treatment process. Only under extreme circumstances in which I present a danger to myself, a danger to others, or if I have a psychiatric illness that causes me to be unable to provide for my own food, shelter or clothing might Dr. Gottlieb institute involuntary treatment. Should I choose to act on self-destructive feelings without first reporting them as agreed herein, or without allowing myself to be hospitalized, I understand that I have violated this consent and that Dr. Gottlieb may choose to withdraw his services or refer me to another psychiatrist.

I understand and acknowledge that I am responsible for all charges incurred by me (or any person that I am responsible for) due to services rendered. I understand that I will be given a complete accounting of all charges incurred and billed, and hereby agree to pay said charges promptly and completely after receiving my bill unless a special written payment agreement is offered by Dr. Gottlieb. I also hereby agree to pay any charges incurred as a result of services rendered by his on-call physician to that doctor should that doctor choose to bill for his or her time.

I understand that even though Dr. Gottlieb has agreed to bill my insurance company for my *out-patient* charges, it remains my responsibility to make sure the bill is paid within a reasonable length of time. If my insurance benefits are paid directly to me instead of to Dr. Gottlieb, upon receipt of said payments I hereby agree to properly endorse the checks and send them to his office. If for any reason any portion of my bill is not paid by my insurance company, I further agree to make prompt arrangements for payment in full of the balance.

_____ _____

Patient's Signature **Date**

_____ _____

Responsible Relative's Signature **Date**

_____ _____

Witness **Date**

Coordination of Care between Health Care Providers and Release of Information

Communication between behavioral providers and your primary care physician (PCP), other behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health provider to share protected health information (PHI) with your other provider. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

Patient Rights

• You may end this authorization (permission to use or disclose information) any time by contacting the practitioner's office.
• If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
• You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
• You have a right to a copy of this signed authorization.
• If you choose not to agree with this request, your benefits or services will not be affected.

Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request. **This consent expires in six (6) months from the date of my signature below unless otherwise stated herein.**

I the undersigned, hereby allow my Dr. Gottlieb and his/her office assistants to contact the following individual or agency:

_____ _____ _____
Healthcare Provider Name Address Telephone

I understand the purpose is to exchange important information for diagnostic and/or therapeutic reasons. Information authorized to be exchanged includes only the following:

[ ] Psychological test results
[ ] Psychiatric hospital records
[ ] Out-Patient treatment report
[ ] Psychotherapy notes
[ ] Vocational test results
[ ] Medical hospital records
[ ] Laboratory test results
[ ] Other:_____

Date consent given: _____/_____/_____ Expires: _____/_____/_____
Print patient name_____
Date of birth _____ Last 4 digits of Social Security # _____

_____ _____
Patient or Legal Guardian Witness

[ ] I hereby refuse to give authorization for any release of information

Consent revoked this _____day of _____, 20_____

_____ _____
Patient Witness

I understand that my records are protected under Federal (42 CFR Part 2) and/or state confidentiality regulations. Upon revocation of authorization, further release of information shall cease immediately. File copy is equivalent to the original. This release of information expires in (30) days following completion or termination of treatment, whichever is later. If information that is released relates to substance abuse treatment, these records confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit anyone who receives these records from any further disclosure of it without specific written consent to the person to whom it pertains. A general authorization for the release of medical information is not sufficient to release substance abuse records. The Federal Rules restrict any use of the information to criminally investigate or prosecute any substance abuse patient. State laws may also protect the confidentiality of patient's records.

Policies and Procedures: Privacy Protection

I. General Policy

It is the policy of this clinic and all clinicians who practice herein to work diligently to protect the privacy of all patients. Clinicians shall always release the ***Minimum Necessary*** information when sharing ***Protected Health Information***, as defined by the Health Insurance Portability and Accountability Act (HIPAA). Information disclosed shall be categorized according to its sensitivity level. Only the lowest level of information required by requesting parties to meet their legitimate needs shall be released. Reasonable safeguards shall also be in place to prevent the incidental disclosure of protected information.

II. Protected Health Information

Protected Health Information is defined herein as personally identifiable medical and psychological records maintained on patients of this clinic as required by state and federal laws. Psychological records shall have a higher level of privacy protection than medical records, shall be kept in a special section of the medical chart, and shall never be released without a signed consent from the involved patient.

III. Who May Request Protected Health Information

Medical and Psychological Clinicians, Office Staff, and Business Associates shall act in compliance with HIPAA regarding the release of Protected Health Information to all requesting parties, including the following:

A. The Patient

Under HIPAA, patients may now request copies of their medical records. Upon review, patients may also place an addendum in their files if they believe their records contain significant errors or omissions. Although patients have the right to request copies of their record, clinicians have the right to charge patients a reasonable fee to cover photocopying expenses. Finally patients have the right to request a list of all parties who have to date requested a copy of their medical records.

B. The Patient's Family

Under HIPAA clinicians shall communicate with the patient's family only the minimum necessary information.

C. Managed Care and Insurance Companies

Managed Care and Insurance Companies may request protected information in order to authorize medically necessary treatment or to verify benefits. Clinicians shall attempt to release the minimum necessary information to enable the successful completion of these tasks. However, should a dispute emerge between clinicians and these companies about what constitutes the minimum necessary information, clinicians shall inform the patients about the dispute and shall five patients the right to refuse to release a higher level of protected information. In such a case patients shall be informed that their refusal may result in non-payment of services by their insurance company, and that they shall be responsible to pay for treatment themselves.

D. Other Medical and Psychological Professionals

Medical and mental health professionals requesting protected information shall be asked to specify the minimum necessary information they require, and shall be given the same.

E. Attorneys

Legal professionals requesting protected information shall be asked to specify the minimum necessary information they require, and shall be given the same.

F. Business Associates

Clinicians' business associates requesting protected information shall be asked to specify the minimum necessary information they require, and shall be given the same.

IV. Levels of Intentional Disclosure

Level 1: Dates of Service, Billing Information, and Name of Treating Clinician. No consent needed.
Level 2: Level 1 Information, plus Diagnosis and Treatment Method(s). Patient consent needed.
Level 3: Level 1 and Level 2 Information, plus Intake Evaluation and Medical Notes. Patient consent needed.
Level 4: Levels 1, 2, & 3 Information plus Psychotherapy Notes. Patient consent needed.

V. Incidental Disclosures

Incidental Disclosures are defined herein as unintentional disclosures that may naturally occur in the everyday practice of medicine and Psychotherapy. Clinicians and office staff shall employ Reasonable Safeguards, as defined by HIPAA and as described below.

A. Waiting Room Procedures:

Patients may sign in on the form provided by the clinic in order to inform office staff of their arrival time. However, to reasonably safeguard against confidentiality breaches, patients may choose to write only their first name on the form. Clinicians and office staff shall refrain from discussing protected information with patients and/or their families in the Waiting Room where other patients or persons may inadvertently overhear this information.

B. Front Office Procedures:

Patient Charts shall be kept either in locked cabinets in the administrative office area, or in locked cabinets in clinician on the front office side counter so clinicians can retrieve them. Reasonable Safeguards to protect patient privacy shall be employed. Filing Cabinets holding patient charts shall be monitored by the office staff during regular business hours, and locked when the office is closed. Patient Charts left on the counter for clinicians will be placed face down, with the patient's names concealed from view. All charts shall be refilled in locked cabinets by the end of regular business hours.

Clinicians and office staff shall also follow special front office procedures as listed below:

1) Telephone Procedures:
Clinicians and office staff may leave messages for patients on answering machines and voice mails at phone numbers provided by the patients. Clinicians and office staff may also leave messages with persons other than the patient. Reasonable Safeguards to protect patient privacy when leaving messages shall be employed. Persons leaving messages shall leave the minimum necessary information such as name, preferred return call phone number and information authorized by the patient at intake to release when leaving phone messages.

2) Fax Procedures:
All faxes containing Protected Health Information shall be sent with a disclaimer notice regarding the confidentiality of the information being sent, in accordance with HIPAA regulations.

3) Marketing Procedures:
No Protected Health Information shall be used for marketing procedures by clinicians, office staff, or business associates, in compliance with HIPAA

By signing below, I hereby acknowledge that I have read, understand, and accept the above privacy protection policies and procedures as required by The Health Insurance Portability and Accountability Act (HIPAA).

_____
Patient

_____
Legal Guardian

_____
Witness